Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON NW MEDICAL CENTER
C/O LAW OFFICE OF P MATTHEW ONEILL
6514 MCNEIL DR BLDG 2 STE 201
AUSTIN TX 78729

Respondent Name
CALIFORNIA INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 6

MFDR Tracking Number
M4-09-0120-01

MFDR Date Received
August 20, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "It is clear the claim was underpaid and the Hospital is entitled at the least to the current Fee Guideline allowable of $8,424.77 plus interest."

Amount in Dispute: $

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider has not submitted any evidence to show that the $15,954.75 meets the statutory standards under the Act for reimbursement of outpatient charges related to a simple finger amputation."

Response Submitted by: Stone Loughlin & Swanson, LLP, 3508 Far West Boulevard, Suite 200, Austin, Texas 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 21, 2007	Outpatient Services	$15,044.65	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
3. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 600 – Reimbursement based on usual, customary and reasonable for this geographic region
   - P32 – PPO Reductions based on agreement with First Health

Findings

1. The insurance carrier denied disputed services with reason code P32 – "PPO Reductions based on agreement with First Health." No documentation was found to support that the disputed services are subject to a contractual agreement between the parties to this dispute. This denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. The requestor's reply to the supplemental response of the carrier asserts that " the claim is properly categorized as inpatient. The attached shows that the clinical and medical criteria show that the amputation is billed as inpatient." 28 Texas Administrative Code §134.401(b)(1)(B), effective August 1, 1997, 22 *Texas Register* 6264, defines inpatient services as "Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." Review of box 17 and 18 on the requestor's medical bill finds that the injured worker was admitted on August 21, 2007 at hour 8. Review of box 6 and box 21 finds that the injured worker was discharged on the same date at hour 22. The submitted documentation supports that the length of stay did not exceed 23 hours; the Division therefore concludes that the services in dispute do not meet the definition of inpatient services.
3. This dispute relates to services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(E), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of any medical records to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
6. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:
   - The requestor's position statement dated August 19, 2009 asserts that "fair and reasonable payment would be the balance of the charges or $15,044.65."
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - The Division has previously found that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors," as stated in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, 22 *Texas Register* 6276. It further states that "Alternative methods of reimbursement were considered… and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges…" 22 *Texas Register* 6268-6269. Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - No documentation was found to support that payment of the requestor's billed charges would result in a fair and reasonable reimbursement for the services in dispute.
   - In the alternative, the requestor's supplemental position statement dated May 9, 2011 asserts that "the expected Medicare reimbursement for the claim at the time the services were provided was $5,891.45. Thus under the current Medicare based fee guideline, the Carrier would be required to pay $8,424.77 or 143% of the Medicare allowable. 200% of Medicare based fee guideline would result in payment of $11,782.90 if calculated on an outpatient basis under the current fee guideline."

- Although documentation was found to support the Medicare rate of reimbursement for comparable inpatient services rendered on the same date, the requestor did not submit documentation to support the Medicare payment calculation for the same or similar services rendered in an outpatient setting on the disputed date of service.
- Neither of the fee guidelines as adopted in 28 Texas Administrative Code §134.403 or §134.404 were in effect at the time the disputed services were rendered.
- While the Division has previously found that Medicare patients are of an equivalent standard of living to workers' compensation patients (22 *Texas Register* 6284), Texas Labor Code §413.011(b) requires that "In determining the appropriate fees, the commissioner shall also develop one or more conversion factors or other payment adjustment factors taking into account economic indicators in health care and the requirements of Subsection (d) . . . This section does not adopt the Medicare fee schedule, and the commissioner may not adopt conversion factors or other payment adjustment factors based solely on those factors as developed by the federal Centers for Medicare and Medicaid Services."
- The requestor did not discuss or present documentation to support how applying the proposed payment adjustment factors as adopted in 28 Texas Administrative Code §134.403 or §134.404, effective for dates of service on or after March 1st, 2008, would provide fair and reasonable reimbursement for the disputed services during the time period that treatment was rendered to the injured worker.
- In the alternative, the requestor's reply to the supplemental response of the carrier, dated June 1, 2011, states that "As further evidence of appropriate payment, a very network the carrier improperly accessed to further under pay the claim actually provided for payment rates of 55% of charges or $8,7531.11, when the Hospital contracted with the network subsequent to the admission made the basis of this dispute"
- As stated above, no documentation was found to support that the services were subject to a contractual fee arrangement between the parties to this dispute.
- The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

  > "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

  Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- In support of the requested alternative reimbursement, the requestor submitted documentation to support the payment terms of a contract that was entered into after the services in dispute were performed. The requestor did not submit a complete copy of the contract, but only a selected exhibit from the contract including the compensation schedule. However, the requestor did not discuss or explain how the sample contract supports the requestor's position that additional payment is due. Review of the submitted documentation finds that the requestor did not establish that the contract sets out a fair and reasonable reimbursement amount. The terms and limitations of the contract cannot be established from the information presented. Nor did the requestor discuss whether the sample contracted rate was typical for the services in dispute for the time period when the services were rendered.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	July 16, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.